MEDICAL HISTORY

Indicate which of your relatives have had any of the following diseases:

Cancer _____ Diabetes _____

Heart Trouble _____ High Blood Pressure _____

Kidney Disease _____ Mental/Emotional Disease _____

Stroke _____ Arthritis _____

Please list any of your known allergies **(medication, food, environmental)** or check the box stating no allergies

Allergy to Iodine: Yes ☐ No ☐ Allergy to Seafood: Yes ☐ No ☐ I have no known allergies ☐

Allergy	Severity (Very Mild, Mild, Moderate, Severe)	Reaction	Onset (childhood, adulthood, unknown)

Please list any medications you are currently taking or check the box stating you are not on any medications

I am not currently taking any medications ☐

Medication	Dosage

Please see other side

Please indicate by checking if you have had significant problems in the below areas. Please comment on special problems.

- ☐ Recent Weight Loss
- ☐ Headaches
- ☐ Trouble with Vision
- ☐ Trouble with Hearing
- ☐ Allergies/Hay Fever
- ☐ Asthma
- ☐ Allergic Reaction to Medication
- ☐ Thyroid
- ☐ Diabetes
- ☐ Skin
- ☐ Anemia or Abnormal Bleeding
- ☐ Heart
- ☐ Circulation
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Lungs (Pneumonia, T.B., etc.)
- ☐ Shortness of Breath (Cough, Pleurisy, Wheezing)
- ☐ Liver Disease, Gallbladder Disease (of Jaundice)
- ☐ Stomach Trouble
- ☐ Swelling in Feet/Ankles
- ☐ Arthritis
- ☐ Depression
- ☐ Psychiatric
- ☐ Fainting or Convulsions
- ☐ Strokes
- ☐ Pain in Other Areas
- ☐ Kidney Disease or Stones
- ☐ Gout
- ☐ Double Jointed
- ☐ Joint Pain or Stiffness
- ☐ Numbness in Feet or Legs
- ☐ Cramps in Feet or Legs

☐ Nutrition, is There Anything We Should Know About Your Eating Habits? _____

☐ Do You Smoke? Never Smoker ☐ Former Smoker ☐ Current every day Smoker ☐ Heavy Tobacco Smoker ☐
Unknown if ever Smoked ☐ Current Some day Smoker ☐ Light Tobacco Smoker ☐

☐ Do You Drink Alchohol? How Much? _____

☐ Do You Take Any Drugs (Illegal or Recreational)? How Much? _____

☐ Ongoing Medical Issues or Additional Illnesses or Problems Not Listed Above? Please Describe _____

_____

_____

_____

Please give details of any major events, hospitalization, or surgeries

Date	Type	Doctor/Surgeon	Clinic/Hospital

Is there anything you wish to tell your physician privately? Yes _____ No _____

Patient's Signature _____ Date _____

Please see other side